KENTUCKY ASSOCIATION of HOSPICE & PALLIATIVE CARE

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Office of Health Policy
c/o Diona Mullins, Policy Advisor
Cabinet for Health and Family Services
275 E. Main Street, 4W-E
Frankfort, KY 40621

Ms. Mullins,

The members of the Kentucky Association of Hospice and Palliative Care (KAHPC) are advocates for quality care for all persons with life limiting illness and believe that all eligible persons should have access to the services hospice has to offer. The Association recognizes the importance of assuring access to high quality health care for the citizens of the Commonwealth and we are pleased to be part of the discussion process and offer our expertise about end of life care in Kentucky.

Background

The Commonwealth of Kentucky has developed a Certificate of Need (CON) program for promoting orderly growth in the number of providers for specific health care services, including hospice care for the terminally ill. Currently 36 states have some type of CON law and Kentucky is one of 12 states that regulate hospice industry growth via CON by using a numeric methodology to determine the unmet need for hospice care in each service area.

In 2006, KAHPC worked with the Cabinet for Health and Family Services (CHFS) to develop a new approach to the determination of the need for additional hospice programs as the existing approach was inflexible and outdated. KAHPC engaged with a national expert who examined

the CON methodologies for eight states, compared them to the Kentucky methodology and applied them to Kentucky. After months of research, KAHPC presented CHFS with the final report which included a suggested new methodology for Kentucky that would be more flexible and insure proper access to care. Ultimately, the suggested methodology was adopted by CHFS for the state health plan.

As maybe the only health care provider to go through such an in depth review and ultimate revision in the recent past, we feel the CON methodology for hospice is in line and is working to ensure access to care as well as high quality care from appropriate providers. In fact, hospice penetration rates based on the Medicare claims from 2000-2013 show an overall statewide increase in penetration rates between 2000 and 2013. [1]

The CON program has been effective in improving access to quality hospice care by creating a set of incentives for managers, administrators and leaders of hospices in Kentucky. The publication of the Kentucky Annual Hospice Utilization Report[2] gives leaders of each program a snapshot of their organization's success in providing access to care relative to other hospices across the state. The Kentucky Annual Hospice Utilization Report is utilized by Kentucky hospices as a valuable benchmark tool. This snapshot provides a powerful incentive for each hospice to constantly work to increase its access and quality relative to its peers in the same and other service areas.

Hospice Model – High Value, High Quality, Full Continuum of Care

As you may be aware, hospice is a unique form of healthcare delivery focused on caring for, not curing a patient. To that end, hospice provides patients with expert medical care and pain management, but also provides emotional and spiritual support as appropriate when requested by the patient and families. Patients who elect to receive hospice care choose to forego curative treatments, opting instead for hospice's medical and supportive care focused on relief of symptoms, promotion of comfort and maximizing quality of life at a time when its duration is known to be limited. In most cases, hospice care is provided in the patient's home but when necessary, it can also be provided in hospice inpatient facilities, nursing homes and other locations the patient may call "home."

Hospice is considered the model for quality compassionate care for people facing a life-limiting illness. Hospice care is centered on the patient and family using an interdisciplinary team which includes physicians, nurses, therapists, social workers, bereavement and spiritual counselors and volunteers. The members of the interdisciplinary team develop a plan of care for the patient that meets their specific and individual needs. Once the plan is in place, family

[1] Kentucky State Summary of Medicare Hospice Utilization
[2] Kentucky Annual Hospice Utilization Report

members will serve as the primary care giver in the home while the hospice staff and members of the team make regular visits to assess the status of the patient and provide any additional care or services or changes that are necessary.

The plan of care includes services that are reasonable and necessary for the comfort and management of the terminal illness. These services include:

- Case management and coordination of care and services related to the terminal condition;
- Physician services;
- Nursing care;
- Physical therapy, occupational therapy and speech-language pathology services;
- Medical social services;
- Home health aide services;
- Homemaker services;
- Medical supplies;
- Drugs and biologics related to the terminal condition;
- Medical appliances and equipment;
- Counseling of the patient, including psychosocial and spiritual counseling, dietary counseling, counseling of the family regarding care of the terminally ill patients and bereavement counseling; and,
- Short-term inpatient care for respite, pain control and symptom management.

Unlike other health care providers, for this full complement of services and coordination of care, hospice is paid a daily, all-inclusive rate designed to cover all care and services necessary to manage a terminal illness for each day the beneficiary is enrolled in hospice. The per-diem rate obligates the hospice to provide needed services such as visits by nurses, aides, chaplains and social workers as well as the medical care and expertise provided by the physician. Hospice providers are the only health care provider paid on a per diem rate and thereby take on the risk associated with the patient's health care costs.

In addition, Medicare has also established a reimbursement cap that limits the total amount that can be paid to a hospice program each year. This cap is based on a per-beneficiary, lifetime ceiling on hospice reimbursement, aggregated and averaged for all Medicare patients served by a particular hospice over the course of a year. The purpose of this cap is to ensure that the hospice benefit remains cost-effective overall. If Medicare determines it has paid a hospice program more than allowed under the cap calculation, the hospice program must pay back the amount of the overpayment.

Also unlike other health care providers, hospice programs are required by federal statute to provide a specific amount of their services through volunteers, 5% of direct care must be provided by volunteers. And hospices also rely on community charity dollars raised to fund their programs. As you can imagine, hospice providers require a very specific skill set and are limited in communities as are the charitable dollars. Multiple hospices in one service area create problems in recruiting a quality health care provider workforce as well as cultivating sufficient charitable contributions.

Kentucky hospices are one of very few who have not exceeded their cap in nearly 20 years. Statistics show that typically, states with a higher supply of hospice providers relative to the number of Medicare deaths exhibit a much higher level of cap violations. In fact, it has been shown that over time the number of cap violations has grown concurrent with rapid growth of providers in states without CON for hospice.

Access and Quality Care Are a Priority

Hospice providers in Kentucky are committed to ensuring access to hospice services to every Kentuckian who wishes to access them. In an effort to ensure access for those in need of hospice services, KAHPC worked with a consultant to review the Kentucky methodology for determining need in an effort to modernize the methodology to ensure adequate coverage and access for Kentuckians. KAHPC submitted the findings of the report to the Cabinet for Health and Family Services which resulted in a change to the calculation to better reflect the needs of the state.

The CON process is important for the hospice industry because of the nature of the business. While it is debatable among groups whether or not health care is a free market industry, it is clear that hospice is not – hospice is a defined benefit with a fixed reimbursement. When price is fixed and supply is fixed the laws of supply and demand no longer apply. Market entry for providing hospice services is relatively easy as it requires minimal capital expenditures. Relaxing or eliminating the certificate of need program for hospice services would jeopardize the ability of the existing community based, not-for-profit programs in Kentucky to provide the highest quality of care to all patients regardless of ability to pay. Many of those in need of hospice services are among the most economically challenged and are most dependent on the health care services and need the protections only the state provides through the certificate of need programs.

The Kentucky CON program has resulted in the development of hospices that provide a level of access and quality of care generally considered among the best in the nation. A couple of states have gone down the path of eliminating the certificate of need requirement and have seen firsthand the unintended consequences of this decision which include a proliferation of

hospice programs, mostly for-profit organizations, generally located in the areas that need them the least. Multiple case studies have shown that without CON, a proliferation of programs results with the greatest concentration in the metropolitan areas with the rural areas of the state rarely effected.

This has resulted in lower quality service and higher rates of programs exceeding the hospice CAP which can be an indicator that patients are being inappropriately admitted to hospice in an effort to help the program survive with so many hospices in one area. In its 2012 Report to Congress, MedPAC analyzed 2009 hospice claims and determined that above-cap hospices tended to be "for profit, freestanding hospices and to have smaller patient loads" (p. 294).[3] In the same report, MedPAC reported that in 2009 above-cap hospices had higher rates of live discharges and beneficiaries utilizing the benefit beyond 180 days across diagnoses. These findings led MedPAC to suggest that some hospices pursue hospice-inappropriate patients whom they later discharge as they near the aggregate cap (i.e., to maximize their revenue potential without creating a cap liability). These are just some of the issues that have been prevalent in states that do not have certificate of need for hospice services.

Looking across the nation, the states we are seeing the most significant problems with inappropriate activity by hospice programs occurs in the states that do not have the protections of a CON program and have an abundance of for profit hospice programs in the state. In Kentucky, we are fortunate to have 22 legacy hospice providers with substantial ties to each community they serve. Hospice was fundamentally founded on being a community based organization which is why it is important for the organization to have ties and responsibilities to the community.

In the recent past Maryland considered elimination of the hospice CON but eventually concluded the process should remain. In 2009, Alabama actually re-enacted CON for hospice programs in order to control unnecessary proliferation of provider supply and the associated adverse consequences. Many reasons are commonly cited for continuation of CON including:

- CON helps preserve high-quality hospice care;

- There is little or no market incentive for hospice providers to offer services in rural, remote portions of the state now served by local hospices with strong community ties. Growth in hospice services resulting from de-regulation is more likely to be pursued by large hospice chains and to take place in communities where there is already adequate coverage;

[3] Available via: http://www.medpac.gov/chapters/Mar12_Ch11.pdf

- An excessive supply of hospice providers within service areas already served by hospice programs will result in competition for the same dollars and some or all of those providers could become insolvent

The CON program in Kentucky allows the established hospice programs to care for patients across the Commonwealth which would become increasingly difficult if hospices were able to start up without restriction and cherry pick those counties which are easier to serve. As you are aware, Kentucky is a rural state and the rural areas are more difficult to provide services for, particularly a service that is delivered in the patient's home. Hospice is a high touch, low technology model of care so it takes more time and costs more to care for patients in the very rural parts of the state. These areas would suffer if new programs were allowed to enter the market and choose at will the counties they are willing to serve. The inevitable result of the loss of CON for hospice, based on experiences of other states and statistical data, would be diminished access to care, less intensive and comprehensive hospice services, less investment by hospices in direct patient care, generally diminished quality of care, substantially increased incidence of fraud and abuse and substantially greater workload and cost for state regulatory agencies resulting in decreased oversight and accountability to the communities served.

History and statistics show that an excess supply of hospice providers does not correlate with a positive impact on access or service availability. However, an oversupply of hospice providers is associated with negative outcomes such as lower levels of hospice expenditures per patient day, higher rates of live discharges and higher rates of reimbursement cap violations – all significant quality concerns.

Strategy for Increasing Access to Hospice Care

While we feel the current updated CON methodology for determining hospice need is working, there is an area we feel we could better serve the citizens of Kentucky – the nursing home.

Hospice is a specialty type of care that is provided in addition to, or in conjunction with, other health services required by the patient. Hospice is required to provide care in the place the patient calls "home" which with an aging population is increasingly becoming the nursing facility. In the case of a nursing facility resident electing hospice care, the hospice is responsible for care related to the terminal condition. The nursing facility provides all care not directly related to the terminal condition.

Studies have shown that hospice in the nursing facility can provide high quality end-of-life care and offer benefits such as reduced hospitalizations and improved pain management. It has also been shown to have a positive effect on non-hospice residents suggesting indirect benefits on nursing facility clinical practices.

In 1999, CHFS was trying to get a handle on the Medicaid room and board rates being paid to nursing facilities. An actuarial study of the nursing facility case mix was used to determine how they could get control of the room and board rates for these facilities. The study looked at hospice patients and found that if they were not included in the case mix for the facility, about 50% of the time there was no effect on the facilities room and board reimbursement but the other 50% of the time the room and board rate was lowered. As a result, CHFS made the decision to be one of four states to take hospice patients out of the case mix for nursing facilities.

Once a nursing facility sees their reimbursement rate decrease due to accepting hospice patients, the facility simply discontinues working with hospice causing a barrier to access for these deserving patients. The number of hospice eligible patients residing in the nursing facilities is growing and will continue to do so as the aged population expands.

There are multiple studies that show the cost savings hospice care realizes for all payors. The 2007 study by Duke University found that hospice saves on average $2300 per patient who elects the benefit. A 2013 study by the Icahn School of Medicine at Mount Sinai confirmed the cost savings realized when hospice services are utilized stating, "Medicare patients who enrolled in hospice received better care at a significantly lower cost to the government than those who did not use the Medicare hospice benefit." In addition, hospice saves state Medicaid dollars for room and board payments for patients who elect hospice in the nursing facility. Medicaid reimburses hospice 95% of the facilities room and board rate and hospice in turn pay the nursing facility 100% of their room and board rate. Had that patient not elected hospice, Medicaid would have been responsible for the entire 100% of the rate. That is a savings of 5% which in Kentucky translates to well over $1.5M annually for the limited population served by hospice in the nursing facility.

The decision to take hospice patients out of the nursing facility case mix in essence treats hospice Medicaid patients living in a nursing facility differently than other non-hospice Medicaid patients in the facility. CMS has weighed in on the issue and verbally clarified this is not appropriate.

As the Cabinet considers making changes to provide a complete continuum of care, the inclusion of hospice care with waiver services could increase access to these important services. Recommendations made in "The Commonwealth of Kentucky Health Care Facility Capacity Report" recommend the expansion/strengthening of Home and Community Based Waiver and Home Health services. Currently, Kentucky residents are limited in the services they can receive. Residents must choose between accessing waiver services (with the exception of attendant care) or the hospice Medicaid benefit. As the Cabinet considers expanding home

health and waiver services, KAHPC asks it to consider the unintended consequences of such expansions. For example, a terminally ill resident who can access both nursing facility and hospice care shouldn't have to lose access to the hospice benefit to choose less expensive waiver services at home. Other states, like Indiana, where Medicaid costs remain low, allow residents access to both services as long as coordination of care is reviewed and duplication of services/costs do not exist.

Hospice services have been meeting the intent of the "Triple Aim" for a number of years. Part of the success of the hospice benefit on cost and outcomes is related to the overall management of the patient and family needs as they relate to the body, mind, and spirit. To that end, we ask the cabinet to consider the value of the holistic approach to care and to ensuring residents of Kentucky are not limited to only physical care during the last six months of life. As referenced earlier, multiple studies support the reduction of Medicare spending when hospice is involved. This becomes a more important consideration as projections in "The Commonwealth of Kentucky Health Care Facility Capacity Report" show increases in demand related to behavioral health.

At a time when everyone, especially Medicaid, is struggling to preserve every dollar possible for services, it is important to look to programs that have proven to be part of the solution for cost savings rather than putting up barriers to access.

By placing hospice patients back in the case mix for nursing facilities, nursing facilities no longer have a financial reason to impede access for their residents to hospice care.

Summary

The hospice model of care is intrinsically consistent with the trend toward a more outpatient centric model of care with the vast majority of care being provided in the home setting which is a much more cost efficient delivery model. Hospice services are reimbursed on a per diem rate rather than a fee for service model. In return for the per diem rate of approximately $138 per day in Kentucky, the hospice assumes the responsibility for all health care costs related to the terminal illness, including prescriptions and durable medical equipment related to the terminal illness, labs, nursing visits and bereavement and spiritual counseling.

As the hospice industry continues to grow across the nation, the industry is focused on capturing meaningful quality measures to ensure the best in class care for hospice patients. While growth is important, it is even more important to ensure that growth is appropriate and focused on delivering the highest quality of care to the patients served. The hospice certificate of need methodology that was recently revised by the Cabinet is working to ensure proper

growth and use of hospice services in the state therefore KAHPC recommends that no further action be taken to alter the current certificate of need process for hospice.

It is the desire of KAHPC to cooperate with the Cabinet in this endeavor and would be glad to meet with you at your request or answer any questions you may have. We appreciate your consideration of our concerns and the work you do on behalf of the health care needs of our citizens.

Sincerely,

Brandy Cantor
Executive Director
Kentucky Association of Hospice and Palliative Care

SELECT STATE
Kentucky

Based on Medicare Claims for 2000-2013

Kentucky State Summary of Medicare Hospice Utilization

Year	Medicare Enrollment	Death Rate per 1,000	Resident Deaths	Hospice Penetration	Patients Served	Days per Patient (ALOS)	Patient Days	ADC	% GIP Days	GIP ADC	
2000	653,091	46.5	30,340	0.29	8,812	50.3	443,195	1,211	2.7%	33.1	366
2001	661,740	46.4	30,693	0.30	9,145	54.5	498,606	1,366	2.8%	37.6	365
2002	670,611	46.5	31,210	0.32	9,851	55.2	544,041	1,491	2.9%	42.6	365
2003	681,824	45.1	30,753	0.34	10,415	54.6	568,371	1,557	2.8%	43.2	365
2004	694,228	42.5	29,481	0.37	10,828	57.5	622,116	1,700	3.0%	50.7	366
2005	713,291	43.2	30,811	0.38	11,610	56.8	659,185	1,806	2.5%	45.6	365
2006	728,913	42.1	30,697	0.40	12,198	56.5	689,183	1,888	2.4%	46.0	365
2007	746,457	41.1	30,657	0.41	12,553	58.6	735,773	2,016	2.4%	48.5	365
2008	763,732	41.8	31,956	0.43	13,592	58.8	799,799	2,185	2.7%	58.9	366
2009	779,328	40.9	31,844	0.44	14,157	59.2	838,374	2,297	3.2%	72.6	365
2010	796,635	40.8	32,514	0.46	15,032	59.9	900,333	2,467	3.0%	73.2	365
2011	820,004	40.5	33,199	0.48	15,779	58.6	925,163	2,535	3.2%	81.9	365
2012	845,866	40.5	34,226	0.49	16,662	57.0	950,513	2,597	3.6%	92.4	366
2013	867,197	40.2	34,874	0.50	17,400	53.2	925,423	2,535	3.7%	94.4	365

	% GIP Days
2000	2.7
2001	2.8
2002	2.9
2003	2.8
2004	3.0
2005	2.5
2006	2.4
2007	2.4
2008	2.7
2009	3.2
2010	3.0
2011	3.2
2012	3.6
2013	3.7